Approved: March 6, 1997
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Don Steffes at 9:00 a.m. on February 24, 1997 in Room 529-S of the Capitol.

All members were present except:

Committee staff present: Dr. William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Whitney Damron, Kansas Psychological Association
Harold Riehm, KS Assoc. of Osteopathic Medicine
Bob Williams, Kansas Pharmacists Association
Gary Robbins, Kansas Optometric Association
David O. Hill, Kansas Psychological Association
Terri Roberts, Kansas State Nurses Assn.
Jim Schwartz, Kansas Employers Coalition on Health
Terry Leatherman, KCCI
Cheryl Dillard, Health Net
Brad Smoot, Blue Cross/Blue Shield
Bruce Witt, Preferred Health Systems, Inc.
John Federico, Humana Health Care Plans
William Sneed, HIAA
Tom Wilder, Kansas Insurance Department
John Peterson, Kaiser Permanente
Steve Kearney, CIGNA

Others attending: See attached list

Hearing on SB 331 - Point of Service

Chairman Steffes reviewed the history of the bill which was conceptually introduced on February 2 in the Senate Financial Institutions and Insurance Committee. The bill was introduced through an exempt committee on February 14, referred to FI&I on February 17 and the hearing date was set on February 20 for February 24. This was only possible because leadership added another day for committee meetings. There was no intent to delay the hearing. Copies of the fiscal note were distributed which informed the Committee that the bill contains no language that would prohibit a provider from billing the patient for any amount not reimbursed by the insurer.

Whitney Damron, Kansas Psychological Association, spoke in support of the bill which would primarily permit health care service consumers to maintain or develop professional relationships with providers of their choice (out-of-network options) as long as they meet the same professional and/or training qualifications of the in-network provider (Attachment 1).

Harold Riehm, Executive Director of the Kansas Association of Osteopathic Medicine, stated their reasons for supporting the bill which would allow more patient choice in health care providers than is currently available now and probably in the future (Attachment 2). At this time managed care options appear to have little to do with quality of care as rewarding contracts are written for providers who have low hospital admissions.

Bob Williams, Executive Director of the Kansas Pharmacists Association, explained that the bill will only allow for 90% reimbursement of the out-of-network pharmacists's dispensing fee and drug reimbursement would be the same as for in-network providers (Attachment 3).

Written testimony from Gary Toebben, President of the Lawrence Chamber of Commerce, supplied written testimony pleading for fairness on behalf of their small business members in the health care industry (Attachment 4).

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Dr. Alex Scott, Silver Haired Legislature, provided written testimony to the Committee members regarding the lack of fit between societal medical needs and the economic remedy being suggested (Attachment 5).

Gary Robbins, Executive Director of the Kansas Optometric Association, reiterated their support of the concept of managed care and supplied testimony regarding their belief that a point of service option will lead to greater competition in health care services and an increase in treatment options for the insureds (Attachment 6).

David O. Hill, Ph.D., Co-Chair of the Legislative Committee of the Kansas Psychological Association, explained the need for patients seeking psychological help to be able to seek coverage by professionals who may not be part of the network and to be allowed more choices in treatment procedure (Attachment 7).

The Association of Community Mental Health Centers of Kansas, Inc., presented written testimony prepared by Ellen Z. Piekalkiewicz (Attachment 8).

Sky Westerlund, Executive Director of the Kansas Chapter of the National Association of Social Workers, explained that health care is a very important and personal and private decision (Attachment 9).

R. E. "Tuck" Duncan, representing the Kansas Occupational Therapy Association, presented written testimony supporting the theory that a patient has the right to choose his or her own health care provider and that it not be restricted because of participation in a managed care plan (Attachment 10).

Terri Roberts, Executive Director of the Kansas State Nurses Association, stated their support of the bill which will provide 90% reimbursement to out-of-network providers (Attachment 11).

James P. Schwartz, Consulting Director of the Kansas Employer Coalition on Health, Inc., said this was more a "provider protection act" as more providers in the free market are finding themselves with decreasing business since they are not part of a managed care plan (Attachment 12). This bill does not affect ERISA plans.

Terry Leatherman, Executive Director of KCCI, told the Committee that cost containment of health costs has been possible due to negotiating contracts regarding costs with health care providers (Attachment 13).

Cheryl Dillard, Vice President of Public Affairs, HealthNet, stated that a mandatory point of service law would work a considerable hardship on small health plans like those that are being considered by rural hospitals (Attachment 14). Eighty percent of managed care plans now have point of service options.

Brad Smoot, Blue Cross/Blue Shield, reminded the Committee that for generations Americans relied upon a fee for service system of health care and the cost of care and health insurance ultimately drove many providers out of the market place (Attachment 15). This is their attempt to re-enter the market by becoming out of network alternatives and not being under the control of a managed care plan. If this legislation is approved, the option of choosing in network providers at a lower cost or out of network providers would not be available. Medical health plan costs would rise 8-11 percent for individuals and raise the cost of providing health insurance for employers drastically.

Bruce Witt, Preferred Health Systems, Inc., said that if this legislation passes, it would severely limit if not eliminate their ability to continue offering high quality, competitively priced health insurance products to employer groups (Attachment 16).

William Sneed, Health Insurance Associations of America, joined those in opposing the bill because it would restrict consumers' rights to contract with a health insurance company, restrict consumers' rights to choose between plans offering different types and levels of benefits, and has the effect of driving up the cost of health insurance (Attachment 17).

John Federico, Humana Health Care Plans, spoke in strong opposition to the proposed legislation which would cause rising health care costs for a segment of the populations who have joined a plan to avoid such costs and are willing to work within the network (Attachment 18).

Tom Wilder, Kansas Insurance Department, stated they had no position on the proposed legislation.

John Peterson, Kaiser Permanente, said the passage of this legislation would force Kaiser Permanente to assume the role of an indemnity insurance company that pays claims on a fee for service basis (Attachment 19).

Steve Kearney, Cigna, spoke in opposition to the bill as it is so broad it would cause Cigna to revamp their

current system of managed care to a system with less control of costs (Attachment 20). By permitting clients to seek pharmaceuticals out of network, the contracting pharmacists will not be able to offer the same discounts to enrolles who chose and understood the offered plan.

Carl C. Schmitthenner, Jr., Kansas Dental Association, presented written testimony supporting the bill (Attachment 21).

The hearing was closed.

The hearing was adjourned at 10:04 a.m. The next meeting is scheduled for February 25, 1997.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2/24/97

NAME	REPRESENTING
John Federico	Pete McGill + Assoc
Tom Wilder	Kansas Ins. Dept
David A. Hill, PhD	Kansas Psych. Assoc.
Whitney Damron	KS Psychological Assn.
TUCK DUNCAN	KS. Occupational therapy Assn.
Danielle Noe	Governor's Office
Sky Westerlund	KS Chapter. Association of Social Wkrs
William W Sneed	HIAA
JERRY SLAUGHTER	KMS
Meg Henson	KMS
GARY Robbins	Ks Optometric Assn
Dudley Havens	SRS
KAREN BRAMAN	SRS
Rebecca R[illegible]	Ks Chiropractic Assn.
Terri Roberts	Kansas State Nurses Assn.
STEVE KEARNEY	CIGNA
Jim Schwartz	KECH
Bruce Witt	Preferred Health Systems
Mary Ellen Conlee	Via Christi Health Partners.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: ______________________________

NAME	REPRESENTING
Riley Guthrie	Health Midwest
Harold Riehm	KADM
Bob Williams	Ks. Pharmacists Assoc.
Bob Alderson	"
[illegible]	"
Cheryl Dillard	HealthNet
Brad Smoot	BCBS
Callie Hill Denton	K. Peterson & Assoc.

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COMMERCE BANK BUILDING
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TOPEKA, KANSAS 66612-1213
(913) 354-1354 ◆ 232-3344 (FAX)

TO: Chairman Don Steffes
and Members of the
Senate Committee on Financial Institutions and Insurance

FROM: Whitney Damron
on behalf of the
Kansas Psychological Association

RE: SB 331 - Point-of-Service Legislation

DATE: February 24, 1997

Good morning Chairman Steffes and Members of the Senate Committee on Financial Institutions and Insurance. My name is Whitney Damron and I appear before you today on behalf of my client, the Kansas Psychological Association, in support of SB 331 guaranteeing a patient the right of access to the health care provider of their choice through an out-of-network guarantee in HMO/Managed Care plans offered in the State of Kansas.

At the outset of my comments, I wish to thank the Chairman for his courtesies and the Committee for your indulgence in hearing this bill today. I realize the limited time you have to consider all of the bills remaining in your committee and appreciate your consideration of this issue.

INTERESTED PARTIES.

Distributed to you this morning is an informational packet which has been prepared in cooperation with the Kansas Patient Choice Protection Coalition. The Coalition is not formally organized through incorporation or membership requirements, but rather is designed to serve as a point of information collection and distribution for those interested in Point-of-Service legislation and related issues in Kansas.

Senate FI&I
Attachment 1
2/24/97

The Mission Statement of the Coalition located in the front of the bound informational packet is intended to serve as the framework of our goals and interests. On the following page you will see a listing of those who have formally endorsed this policy statement and support the guarantee of a Point-of-Service option for all HMO/Managed Care plans offered in Kansas. Those organizations include:

Kansas Optometric Association
Kansas Dental Association
Kansas Association of Osteopathic Medicine
Kansas Psychological Association
The Silver Haired Legislature
Lawrence Chamber of Commerce

In all, twelve provider and public interest organizations have formally indicated their support for this issue.

BACKGROUND AND DEFINITIONS.

By way of background, I will attempt to explain what a Point-of-Service option is, and perhaps more importantly, what it is not.

"Point-of-Service Option" means that a member or subscriber of a Health Maintenance Organization (HMO) or Managed Care Plan may seek health care services from a provider that is not specifically contracted to their HMO/Managed Care plan.

Related terms are "In-Network Provider" and Out-of-Network Provider".

An "In-Network Provider" would be a health care provider who has contractually agreed to perform services to subscribers of an HMO/Managed Care plan, while an "Out-of-Network Provider" would be a person not under contract. Typically an HMO/Managed Care plan subscriber cannot receive reimbursement for services received from an Out-of-Network Provider unless the enrollee's plan has a Point-of-Service option.

When a Point-of-Service option is included in an HMO/Managed Care plan, lower rates of reimbursement or higher "co-pays" are typically required in order to compensate the HMO/Managed Care plan for services provided by non-contracted health care providers. SB 331 includes a lower rate of compensation for Out-of-Network providers, which I will explain later in my comments.

What SB 331 is not is "Any Willing Provider" legislation. You have likely heard comments from those opposed to this legislation that it is an "Any Willing Provider" bill. I, too, have heard those comments as have others interested in this legislation. Although the concepts are somewhat similar in generic terminology, they differ greatly in scope, application and cost.

"Any Willing Provider" legislation would require insurers, HMO's and Managed Care plans to approve for reimbursement any health care provider willing and able to meet the terms and conditions established by the health care plan. The Out-of-Network guarantee in SB 331 limits treatment to a "qualified health care provider" who has the same professional and/or training qualifications of the In-Network provider.

WHY IS AN "OUT-OF-NETWORK" OPTION IMPORTANT?

- Permits health care service consumers to maintain or develop professional relationships with providers of their choice.
- Permits continuity of health care service when employers change insurance carriers and HMO/Managed Care plans change providers.
- Out-of-Network options are particularly critical in rural areas where the availability of In-Network providers may be limited or nonexistent.
- Acts as a quality assurance check for HMO/Managed Care plans by permitting patients who are dissatisfied with services from In-Network providers to seek care from Out-of-Network providers.
- Health care services are not generic commodities. Health care services are generally of a highly personal nature and best results occur with the free exchange of information between a health care consumer and a

health care provider, achieved through mutual trust, consumer satisfaction and confidence in services received.

HOW WAS SB 331 DRAFTED?

During the 1996 Legislative Session, HB 2985 was introduced in the House Financial Institutions and Insurance Committee at the request of the Kansas Psychological Association and other provider groups. Although hearings were held on the bill, the bill was not formally considered primarily due to the fact that an Impact Report required by K.S.A. 40-2248 and 40-2249 had not been performed.

Using HB 2985 as a basis, the provider groups listed in the informational packet were requested to review the bill from last year and make comments and suggestions for a new proposal for 1997. The standard for reimbursement in HB 2985 was set at *"70 percent of the reasonable charges for such services..."*. Upon further review and deliberation, it was noted that with such a standard for reimbursement, an Out-of-Network provider could actually receive a greater reimbursement amount for services than an In-Network provider, in cases where discounts for services over 30 percent had been negotiated by an HMO/Managed Care plan. To eliminate this possibility, a flat-rate reimbursement standard which guarantees that an Out-of-Network provider will receive less than an In-Network provider for covered services was adopted.

OVERVIEW OF SB 331.

SB 331 would require HMO/Managed Care policies offered in Kansas to include a Point-of-Service option for their enrollees. The primary changes to current law are found in New Section 1. (b), beginning on line 12 of Page 2 and continuing through line 29 of that page.

Reimbursement rates for health care services from Out-of-Network providers could be lower than reimbursements for "In-Network" providers, but not less than 90 percent of In-Network reimbursement rates.

Pharmacists are treated differently under this section, in that their reimbursement rates are bifurcated into "services" and "products". Under the bill, Pharmacists would generally be reimbursed at the same rate as In-Network providers for prescription legend drugs and not less than 90 percent for their services. Bob Williams of the Kansas Pharmacists Association will explain this distinction in greater detail during presentation of his comments.

Quite simply, HMO/Managed Care plan subscribers would be allowed to seek treatment and services from the provider of their choice, but would receive reduced benefits from their plan if they seek treatment from Out-of-Network providers.

IMPACT REPORT.

Included with the informational packet is an Impact Report conducted by Coopers & Lybrand, L.L.P. With that information you will find the statutory references which require an Impact Report to be completed and submitted to the Legislature prior to consideration of a material change in mandated health care coverage. This report was funded by the majority of the provider groups listed with the Mission Statement. I have also included the engagement letter proffered by Coopers & Lybrand, which includes references to the cost of this study, to provide you with some insight as to our commitment to this effort and our interest in obtaining the best information possible prior to seeking Point-of-Service legislation. Dr. David Hill, Ph.D., Co-Legislative Chair of the Kansas Psychological Association, served as the primary contact person with Coopers & Lybrand and together we will attempt to respond to any questions you might have regarding this study and the results contained in the report due to the unavailability of appropriate personnel from Coopers & Lybrand due to the short notice we had available in preparation for this hearing.

According to the Coopers & Lybrand report, the following observations can be made assuming a Point-of-Service guarantee for HMO/Managed Care plans in Kansas similar to that contained in SB 331:

- The availability of coverage for Out-of-Network providers will result in higher health care utilization rates for HMO/Managed Care plans. Simply stated, more people will subscribe to HMO/Managed Care plans when a Point-of-Service option is guaranteed.

- The average cost of HMO/Managed Care products will increase 3.14 percent with the adoption of a Point-of-Service guarantee.

QUESTIONS AND ANSWERS.

Question: Will HMO/Managed Care plans find it difficult to attract qualified health care providers to their networks if a provider doesn't have to be in a network to receive payment for services?

Answer: No. Out-of-Network providers would receive a lower reimbursement rate for their services than In-Network providers. It would continue to be more beneficial to be an In-Network provider, from a reimbursement perspective.

Question: Will Point-of-Service enhance or decrease competition for health care services?

Answer: By guaranteeing that HMO/Managed Care enrollees can seek services from a qualified Out-of-Network health care provider, such plans will encourage competition among HMO/Managed Care plans to contract with the most qualified providers available, particularly those with high enrollee approval ratings.

SUMMARY COMMENTS.

Many HMO/Managed Care plans already offer a Point-of-Service option for their enrollees. However, all do not. Consumer choice is not as simple as seeking another health care insurance provider since many consumers have no choice in their health care coverage provider but simply must accept what is available to them through their employer.

When opponents to SB 331 take the podium later this morning, we assume you will hear comments as to why a Point-of-Service guarantee would inflict great expense and harm upon the managed health care industry in Kansas. That is certainly not our intent. In your deliberations of this issue, we would respectfully request you to ask for more than mere anecdotal evidence against a Point-of-Service guarantee and examine the facts and issues as they are known or can be determined. We have attempted to comply with Kansas statutes by providing accurate and thorough information regarding the implications of this bill through a statutorily-required Impact Report. We would ask for similar research and documentation from our opponents as to the problems this legislation will create for their respective companies before discounting a Point-of-Service guarantee as too expensive or unworkable in the managed care industry.

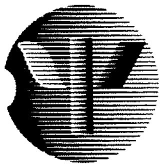
Before concluding, I would call your attention to the comments submitted by former legislator Dr. Alex Scott, M.D. of the Silver Haired legislature and the Lawrence Chamber of Commerce. Point-of-Service is not simply a provider bill -- SB 331 is a consumer bill which affects all of us.

And finally, in health care, the patient's best interest should be the most important consideration. Unfortunately the patient's best interests often do not coincide with the best interest of the insurer, HMO or Managed Care plan or their shareholders. Patient choice is the most critical consumer protection tool available to a consumer against a poorly managed health care plan.

On behalf of the Kansas Psychological Association, I thank you for the opportunity to make these comments this morning in support of SB 331.

I would be pleased to stand for questions at the appropriate time.

WBD:jd
Attachment: Americal Psychological Association comments on Federal Point-of-Service legislation.



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Patient Choice in Managed Health Plans

The American Psychological Association believes that Congress must pass health care legislation that preserves patient choice by ensuring that individuals enrolled in managed care health plans have the option to seek needed health services out of the provider network when they are concerned with the type or quality of care they receive in the plan.

Legislation must ensure that enrollees in all managed care plans have the right to access the provider of their choice by having an out-of-network guarantee. Such an arrangement:

- permits enrollees to retain or develop professional relationships with providers of their choice. This is particularly important in rural areas, where a strong sense of community reinforces the use of local providers, and where it is often geographically impossible to access providers within a specific network.
- enables enrollees to access appropriate specialized health services for themselves and their families.
- acts as a quality assurance check for managed care plans by permitting patients who are dissatisfied to seek care from specialists or providers outside the network.
- minimizes adverse selection thereby keeping costs to the overall system from skyrocketing when higher utilizers stay in fee-for-service plans.

A health plan may include an out-of-network guarantee at minimal or no additional cost to the health plan. To get medically or psychologically necessary out-of-network care, patients agree to pay a higher, reasonable copayment at the time they need the care. The health plan pays a portion of the outside provider's bill, though no more than it pays a network provider, and the patient pays the balance as a copayment. Milliman & Robertson, Inc. determined in 1994 that **open-ended plans would not present a financial drain on health plans**, depending on the level of discounts negotiated with network providers.

A "point-of-service" option is a type of out-of-network guarantee, but isn't part of every health plan. For most HMOs offering a point-of-service option, only 10% or fewer of enrolled individuals use out-of-network services. Nearly 35% of mental health services, however, are sought to be provided out of the network. Therefore, **it is particularly important for persons needing mental health and substance abuse services to be able to access the provider of their choice for reasons of comfort, confidentiality and treatment success.**

Many managed care plans are recognizing the importance of permitting patient choice, indicating consumer resistance to being locked into provider panels:

- Much of the growth in managed care is in "open-ended" HMOs where all enrollees have out-of-network coverage and in HMO point-of-service option plans. These two categories grew 5.4% in 1993, to enrollment of almost 7.2 million, according to Marion Merrell Dow Managed Care Digest, 1994.
- Kaiser Permanente, the nation's largest prepaid health plan with more than 6.6 million members, and U.S. Healthcare, one of the largest HMO companies, began offering point-of-service options for their enrollees as of 1994.
- The number of employers offering a point-of-service plan grew from 7% in 1993 to 15% in 1994, revealed the annual study by Foster Higgins.

April 27, 1995
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Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

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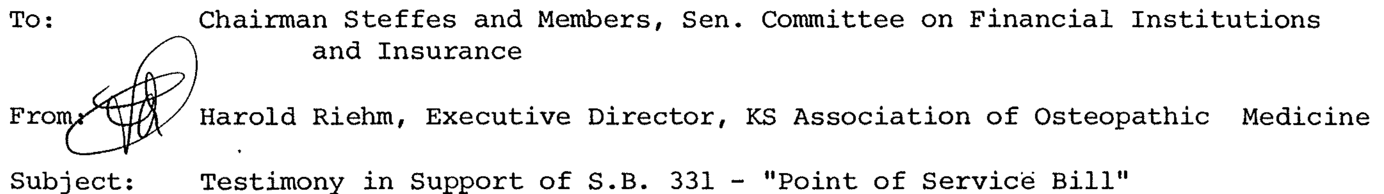
(913) 234-5564 Fax

February 24, 1997



To: Chairman Steffes and Members, Sen. Committee on Financial Institutions and Insurance

From: Harold Riehm, Executive Director, KS Association of Osteopathic Medicine

Subject: Testimony in Support of S.B. 331 - "Point of Service Bill"

Thank you for this opportunity to present our views on S.B. 331 and for hearing the Bill this late in the Session.

We appear in support of S.B. 331. Semantically, may we also refer to this Bill as Patient Protection Act-II, in that it addresses a practice by some insurance and managed care companies that restricts patient choice and elevates quantitative measurement significantly beyond that of quality of patient care.

While limitation of providers may not be prevalent at all place in Kansas--or with all insurance/managed care companies, we think it inevitable it will become more prevalent as managed care coverage increases in the State. Thus this is a preventative measure, in part.

Below I list the reasons we support S.B. 331. I will be pleased to elaborate in my verbal presentation.

(1) When selection of network providers is made, creteria of selection usually include quantitative of cost measurements, i.e., number of referrals, hospital admissions, selection of pharmaceuticals, etc. While these measure quantity, they do not necessairly measure quality. A patient convinced he or she can obtain higher quality from a non-network provider, may be precluded from making that choice if the provider is not included in the network, unless the patient is prepared to assume all costs him or herself.

(2) Qualitative analysis, such as outcomes review, is in the infancy stage and until it is perfected, we think patients need to have a choice of provider, including those not in the network.

(3) Examples: Woman's choice of OB GYN when not in Network; Choice of family practice physician who may be excluded due to a new Company; osteopathic orthopedic surgeon excluded from panel, thus denying this type of care.

(4) Statement of credentialing qualifications, such as requirement for family practice certification, need to have exceptions to cover those non-certified physicians with years of experience in delivering care.

(5) As managed care makes greater inroads into Kansas, restriction of provider networks will increase in number and intensity. With capitation of payment, even more providers will be excluded from the network, thus denying patient choice.

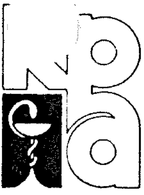
Senate FI&I
Attachment 2
2/24/97

In conclusion, we make two points. First, you will probably hear testimony today that were point of service provisions incorporated in Kansas law, managed care representatives will suggest this will make capitation difficult if not impossible, thus damaging this important cost containment development. We respectfully suggest there is some hyperbole in such statements. Some states have gone far beyond the provisions of S.B. 331 and adopted "Any Willing Provider" legislation. Somehow, we think managed care companies will find a way to survive both in those States and in Kansas with "point of service".

Second, we know of your interest in groups resolving or compromising outside the legislative arena, when they have differences. Though we have not met with managed care representatives, compromise is inherent in S.B. 331. Payment to non-network providers would be at the 90% level, rather than the leve_ for network providers provided by the network plan.

We think S.B. 311 is an important step in guaranteeing patient choice of providers among those provider groups included in networks. We hope it is added to the list of practices than enhance patient choice and quality of care.

I will be pleased to respond to questions.



THE KANSAS PHARMACISTS ASSOCIATION
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ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

TESTIMONY

Senate Committee
Financial Institutions and Insurance
February 24, 1997

SB 331

My name is Bob Williams. I am the Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the committee regarding Senate Bill 331.

Access to quality health care services has become a growing concern for pharmacists and their patients. In increasing numbers, patients are being forced to sever long-standing professional relationships they have had with their pharmacists for many years. The pharmacist/patient relationship is every bit as important as the patient's relationship to other health care providers. Drug therapy is still the most cost effective means of treating many medical conditions. Closed networks can create barriers which could prevent patients from obtaining their necessary medication. This can result in poor health care outcomes which create higher costs in other areas. Many patients would prefer to choose their own health care provider, even if it means they have to pay an additional amount. SB 331 will allow them the opportunity to make that choice.

Lines 21 to 29 on page two of the bill specifically identify reimbursement for prescription legend drugs. Unlike most other health care providers, a pharmacist's reimbursement is composed of two parts: the product (drug) cost and his/her professional(dispensing) fee. However, in this day and age of managed care, it is not unusual for the drug reimbursement to be so low that 90% of that amount would be below the pharmacist's actual drug purchase price. Therefore, the 90% reimbursement would only be applicable to the pharmacist's dispensing fee. The drug reimbursement would be the same as for in-network providers.

Senate FI & I
Attachment 3
2/24/97

-over-

SB 331 is pro-consumer. It provides patients an option if they perceive they are not receiving appropriate care from a given network or provider and allows them the opportunity to stay with a provider with whom they feel comfortable.

We encourage your support of SB 331.

Thank you.

(913) 865-4411
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Senate Bill 331 - Point of Service Legislation
Senate Committee on Financial Institutions and Insurance
Gary Toebben, President
Lawrence Chamber of Commerce
February 24, 1997

Chairman Steffes and Members of the Committee:

As President of the Lawrence Chamber of Commerce, this testimony is on behalf of our small business members in the health care industry. These small businesses want the opportunity to continue to serve their customers and clients and they are willing to do so at or below the discounted rate schedule negotiated by major third-party payors with other network providers.

These small businesses are not asking for special treatment or for a higher payment schedule. They simply want the opportunity to play in the game. They want the opportunity to continue to compete for their customers based on price, the quality of their care, and the quality of their service.

Small businesses in the health care industry have dedicated their lives and in many cases their personal savings to developing well-trained staffs that offer quality care and personalized customer service. If these professionals and their staffs are willing to live with the discounted rates negotiated by third-party payors (or 90% of that rate), they should have the opportunity to compete.

If price and quality of care and service are competitive, small businesses should not be disqualified just because they are small. When you think about it, disqualifying someone simply because he or she is small seems counter to the basic premise of free enterprise.

Thank you for considering the economic welfare of the hundreds, perhaps thousands, of small businesses in the health care industry across our state. Thank you also for considering the freedom of choice that health care consumers will be given under this legislation.

I know that there are many points to be considered when discussing this legislation, but for my small business members in the health care industry, it boils down to one issue, FAIRNESS.

Thank you very much for your consideration.

734 VERMONT
SUITE 101
P.O. BOX 586
LAWRENCE, KS 66044

Senate FI&I
Attachment 4
2/24/97

Testimony
of
Alex Scott, M.D.

Testimony on Managed Care: Senate Bill No. 331

Mr. Chairman and Members of the Committee:

The Silver Haired Legislature has made access to health care providers as one of their top priorities. HMO/Managed Care Plans have been a great conception which has failed in the laboratory of application. Sold as "Preventative Medicine" where everyone would get physical examinations and early detection of disease would decrease the cost of curing the diseases not already prevented by immunizations, healthy life styles, ideal diets, and herbs and nostrums from the health food store. Late in the course of a disease such as cancer, the easier detected. Early diagnosis requires sophisticated, expensive, techniques often requiring a specialist or super specialist.

The screening "gatekeeper" who is in charge of this early diagnosis and treatment is paid for the size of his panel of patients. If he/she has a lucky year with few referrals and a pretty good bonus payment for that year and for two or three more, the insurer will probably renegotiate the contract. On the other hand, if there have, of necessity been too many referrals to specialists another physician can be found to replace the generator of high costs. In either instance, it is his medical liability as he bets on his diagnostic and therapeutic acumen.

Then there is the call in for approval from someone who is trained to operate a computer which will make the decision on hospital admissions. And how many days allowable.

This is health care out of a treatise by the philosopher Kafka!

This appears to be a shotgun marriage (there used to be such a thing) between the infinite variety found in the world of biology and the regimented cyphers of economic statistics. To simplify: The Biologic Foot does not fit comfortably in the Economic Shoe!

If you are vigorous and healthy and remain that way, this not need be a concern of you and yours. The bell will toll for someone else who doesn't really matter too much. Yet sooner or later as the poet, John Donne wrote, "Ask not to know for whom the bell tolls. It tolls for thee."

Senate F I & I
Attachment 5
2/24/97

Good health care is good economics. It reduces costs, it increases productivity, has helped us build this great country, invade space and test the outer limits. It should not enrich executives expense of human suffering that is, in large part amenable to good care.

I thank you for the opportunity to lay these words before you,

With sincerity and appreciation,

Alex Scott, MD

P.S. I, and the Silver Haired Legislature, strongly endorse the intent of Senate Bill 331.

Kansas Optometric Association

1266 SW Topeka Blvd., Topeka, KS 66612
913-232-0225

TESTIMONY ON SENATE BILL 331
SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE
February 24, 1997

Good morning, Chairman Steffes and Members of the Senate Committee on Financial Institutions and Insurance. My name is Gary Robbins, Executive Director of the Kansas Optometric Association. I appear before you today in support of the Point-of-Service provisions contained in S.B. 331.

At the outset of my testimony, I wish to make it clear that the Kansas Optometric Association supports the concept and appreciates the benefits of managed care. However, we believe all managed care plans should include a provision which would allow a patient to seek treatment from a provider of their own choice if their provider is not a member of a managed care plan. The bill before you sets a lower reimbursement rate for out-of-network providers — a concept which we support. Patients who seek health care services out of their HMO provider network traditionally have a higher co-pay or financial penalty to help cover the costs associated with out-of-network services.

The Kansas Optometric Association believes a point-of-service option in HMO and Managed Care plans will lead to greater competition in health care services and increase treatment options for the insureds. Further, it allows for the continuity of care and treatment in the ongoing doctor/patient relationship which can be disrupted when a new managed care plan is implemented.

The Kansas Optometric Association encourages this Committee and the Kansas Legislature to continue to give serious consideration to this issue. We stand ready to assist you and others during your deliberations.

Affiliated with
American Optometric Association TM

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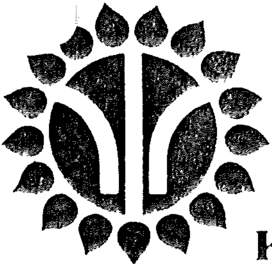

KANSAS PSΨCHOLOGICAL ASSOCIATION

February 24, 1997

Presentation to the Senate Committee on Financial Institutions and Insurance

RE: Reasons to Support SB 331

Presented by David O. Hill, Ph.D.
Co-Chair, Legislative Committee
Kansas Psychological Association

Introduction:

In order for a Mental Health Care Delivery system to meet high quality of care standards, freedom of choice for mental health consumers must be protected. The need to develop and maintain a comfortable and trusting relationship in the choice of a mental health care provider is underscored by the finding that consumers go out of network (OON) to see a mental health specialist about as often as they seek the services of an obstetrician/gynecologist outside the network. The freedom to choose one's own provider is also particularly important in rural areas, where a need for privacy may necessitate choosing a provider outside one's own community.

SB 331 is designed to guarantee that Kansans will always have the right to exercise freedom of choice in selecting health care providers, including mental health care providers. Yet at the same time, SB 331 does not significantly increase costs because it allows plans to continue their managed care practices, while guaranteeing that OON costs will always remain lower than in network costs.

What SB 331 is designed to accomplish:

* Guarantee a patient's access to affordable, quality health care services from the provider of the patient's choice.

* Establishes that a patient will have a right to choose his or her own health care provider even if they participate in an HMO or other managed care plan.

* Permits subscribers to HMO's and other managed care plans to

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seek treatment and services from qualified health care providers of their choice when those patients are willing to pay, if necessary, a higher reasonable copay and/or deductible.

* Acts as a quality assurance check for managed care plans by permitting patients who are dissatisfied to seek care from specialists or providers outside the network.

* Reduces the fear some patients have in signing up for HMO's and managed care plans that are increasingly seen as limiting and difficult to relate to.

* Follows a trend in the insurance industry to offer Point-of-Service plans to potential enrollees.

* Provides an essential safeguard for mental health consumers in a marketplace that has become more confusing and difficult deal with. The imposition of pre-certification, for example has made it more difficult for mental health consumers to interface with a complex system, often at a time when the consumer is already distraught.

What SB 331 does not attempt to accomplish:

* It does not establish new benefits or in any way mandate the services covered by a health insurance plan.

* It is not an any willing provider plan since it does not open up a panel to health care providers heretofore excluded by a plan.

* It does not modify or in any way change limits on benefits.

* It does not undermine an insurance company's ability to authorize what is medically necessary.

* It does not introduce a new concept, in fact many managed care plans already offer Point-of-Service options.

* It does not add to the cost of Preferred Provider Organizations nor to Point-of-Service plans and only creates a negligible increase in cost to HMO's. This increase in

cost occurs in part because more individuals will sign up for HMO plans knowing they have the protection of a Point-of-Service option.

* SB 331 does not interfere with managed care practices. Those practices will remain the same as for in network providers. In the case of HMO's for example, a patient must still consult with the primary care provider who will continue to determine medical necessity and may recommend an in network provider. However, the Point of Service bill leaves the patient with the option to specify an OON provider if desired. In this case, the primary care provider would make that referral.

Summary:

The recent surge in enrollment in point of service plans offered by some managed care organizations has demonstrated that consumers demand the right to choose their mental health providers. Despite the claims made by opponents of this bill that SB 331 represents "the end of managed care as we know it", the evidence from the Coopers and Lybrand impact study is that it is quite feasible economically to provide freedom of choice to consumers. This is underscored by the fact that the Point-of-Service option is one of the fastest growing products currently being marketed by insurance companies. For example, an August, 1994 article in the Kansas City Star revealed that Kaiser Permanente, at that time the nation's largest prepaid health plan and U.S. Healthcare, another of the largest HMO companies, began offering point-of-service options for their enrollees in response to consumer demands.

In terms of mental health care in particular, there is ample evidence that providing easily accessible outpatient mental health treatment can lower medical expenditures overall. Research estimates that 50 to 70% of all visits to primary care physicians are made by individuals who have no identifiable physical illness but whose complaints stem from psychological factors. If mental health treatment were made more available to these patients, utilization of medical services would be reduced, generating significant cost savings. Research in a variety of settings including business and industry as well as Medicare and CHAMPUS has demonstrated that providing readily available mental health services decreases the use of services for physical illness. Further, freedom of Choice for consumers provides a quality

control check, since the patient has the option to seek services from another provider if appropriate.

The Kansas Psychological Association believes that SB 331 provides a much needed change in freedom of choice for Kansans. Our association encourages the Committee to act favorably on this legislation. Please contact us if we can provide further information.

Association of Community Mental Health Centers of Kansas, Inc.
700 SW Harrison, Suite 1420, Topeka, KS 66603-3755
Telephone (913) 234-4773 Fax (913) 234-3189

Testimony to Senate Committee on
Financial Institutions and Insurance
on S.B. 331
February 24, 1997
Ellen Z. Piekalkiewicz

Ron Denney
President
Independence

David Wiebe
President Elect
Mission

Scott Jackson
Vice President
Columbus

Kermit George
Secretary
Hays

Keith Rickard
Treasurer
Leavenworth

David Boyd
Member at Large
Columbus

Bill Persinger
Past President
Topeka

Paul M. Klotz
Executive Director
Topeka

The Association of Community Mental Health Centers represents the 30 licensed Community Mental Health Centers (CMHCs) in Kansas. The CMHCs provide mental health services to approximately 100,000 Kansans in over 100 locations in all 105 counties.

The Association supports the intent of S.B. 331 which is to ensure that consumers receiving health care under managed care plans or any individual health insurance policy are able to receive services from their provider of choice. In the field of mental health it is important for consumers, especially children, who have a relationship established with their therapists to be able to continue seeing that therapist even if that provider is not included in a network plan.

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National Association of Social Workers

KANSAS CHAPTER

To: Senator Don Steffes, Chairperson, Senate Committee on Financial Institutions and Insurance and Members of the Committee

From: Sky Westerlund, Executive Director, Kansas Chapter, National Association of Social Workers

Date: February 21, 1997

RE: SB 331 Point of Service Legislation

The Kansas Chapter, NASW represents 1800 members statewide and the 1300 Licensed Specialist Clinical Social Workers that provide mental health car in every community in Kansas in the public and private sectors. We are pleased to support SB 331 regarding Point of Service for consumers.

Social Workers are the largest group of mental health providers in the state and in the nation. We believe that access to health care is a very important personal and private decision. Point of Service legislation helps the consumer to better access and decision making about their health care, increases the diversity and geographic dispersion of providers, improves the delivery of health care services.

We appreciate the opportunity to provide testimony in support of SB 331.

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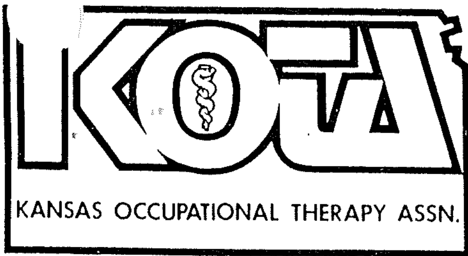
700 SW Jackson Street, Suite 901, Topeka, Kansas 66603-3758 • TEL. (800) 776-4806 or (913) 354-4804 • FAX (913) 354-1456



214 S.W. 7th Street
Topeka, KS 66603
(913) 233-4111

February 24, 1997

To: Senate Committee on Financial Institutions and Insurance

From: R.E. "Tuck" Duncan
Kansas Occupational Therapy Association

RE: Senate Bill 331

The Kansas Occupational Therapy Association supports point of service legislation as set forth in Senate Bill 331. K.O.T.A believes that a patient's right to choose his or her own health care provider should not be restricted because of participation in a managed care plan. We join with the comments of other supporters of this legislation.

Attached hereto for your reference is information of interest about occupational therapy services. Thank you for your attention to and consideration of this matter.

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700 SW Jackson, Suite 601
Topeka, Kansas 66603-3731

913/233-8638 * FAX 913/233-5222

the Voice of Nursing in Kansas

Betty Smith-Campbell, Ph.D., R.N.
President

Terri Roberts, J.D., R.N.
Executive Director

FOR MORE INFORMATION CONTACT:
Terri Roberts JD, RN
700 SW Jackson, Suite 601
Topeka, KS 66603-3731
(913) 233-8638

February 24, 1997

S.B. 331 Point of Service Provider Legislation

WRITTEN TESTIMONY

Chairperson Steffes and members of the Senate Financial Institutions and Insurance Committee, the Kansas State Nurses Association is very supportive of S.B. 331 which will provide 90% reimbursement to "out of network" providers for covered services provided by non-network providers for Kansas HMO policy holders.

There are four categories of advanced registered nurse practitioners currently practicing in Kansas that are extremely supportive of this legislation and the choice that it will provide HMO clients for selecting providers. The four categories of ARNP's include CRNA's (Certified Registered Nurse Anesthetists), Nurse Practitioners, Clinical Nurse Specialists and Certified Nurse Midwives. Additionally, home health agencies not included in networks will be permitted to contract with individuals in their communities for services and recieve compensation at 90% of network reimbursement. In some of the more rural parts of the state this will provide tremendous access that may otherwise be problematic for some HMO policy holders. One of the very important elements of this proposed legislation is that it does not affect those HMO contracts that already have Out-of-network provider clauses, of which over 80% of Kansas HMO's are reported to have.

Thank you.

Senate FI&I

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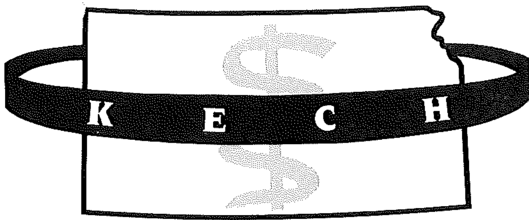

Kansas Employer Coalition on Health, Inc.
214 1/2 S.W. 7th Street, Suite A • Topeka, Kansas 66603
(913) 233-0351 • FAX (913) 233-0384

Testimony to Senate Committee on Financial Institutions and Insurance

on SB 331

(Requiring 90% payment for out-of-network services)

by James P. Schwartz Jr.
Consulting Director
February 24, 1997

I am Jim Schwartz, director of the Kansas Employer Coalition on Health. The Coalition is scores of employers across Kansas, like Sprint, Hallmark, Coleman, and Western Resources, who share concerns about the cost-effectiveness of health care we purchase for nearly 200,000 Kansas employees and dependents.

Even though most Coalition members are self-insured and thus exempt from state health insurance mandates, KECH feels obliged to speak up for those smaller groups who are not exempt, yet sponsor coverage for most Kansans. After all, small groups pay far higher rates already and are least able to absorb the effects of new mandates.

SB 331 has been characterized by proponents as a "patient protection act," but *"provider* protection act" would seem more apt. Let me explain. Health care costs have flattened out in the past three years, mainly because of the switch to managed care, which contracts with exclusive networks of providers. Most studies show that patients are well satisfied with this arrangement. Network providers are reasonably content with this arrangement, too, given that the good old days of blank check medicine are gone. But providers who are not well involved with networks have seen their patient volume and their livelihoods diminished. Those providers who are not faring so well in the free market for managed care now seek protection by you. A provider protection act.

Two issues are raised by the proposed mandates in SB 331. The first is requiring HMOs and similar organizations to provide out-of-network coverage. To me this is like requiring groceries that sell broccoli to also sell cauliflower. Where's the beef? If there's a demand for cauliflower, you'll see it on the shelf soon enough. And already we've seen the emergence in Kansas of several open or "point of service" plans. If purchasers want and are willing to pay for those kinds of plans, they're available. This bill, though, would

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require exclusive plans to undermine their existing contracts by providing access to more providers than are needed to care for enrollees. This situation is inefficient and administratively burdensome, and prices will eventually rise.

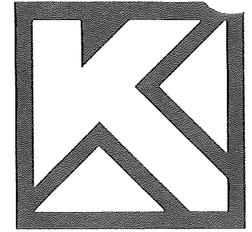
The second issue is the 90% payment requirement. Managed care plans contract with providers on the basis of promised volume of patients in return for discounted fees from providers. The volume of patients depends on the ability of plans to motivate those patients to patronize only network providers. If the motivation to stay in-network is weak, the promise of volume is weak. If the promise of volume is weak, providers are unwilling to lower their fees. Managed care plans that include out-of network-coverage typically use 20 to 30% differentials in copayments for out-of-network care. Sometimes more. If patients know they can go to any provider they want for only a nominal extra fee like 10%, then the covenant between plan and network provider is ruined. That's exactly what some of the proponents of this bill want.

Managed care is still in the process of being invented in this country. Other countries are starting to adopt its principles to replace their rigid, bureaucratic, rationing systems. Of course some controls are needed, like the sensible patient protections in SB 286. And I'd be the first to say that more choice for patients is desirable. But the way to get that choice is by fostering multiple choice of plan within each insured group. Purchasing cooperatives are the ideal way to do this, and this legislature could help that movement along. The wrong way is by making each plan try to act like a cheap ticket to the entire healthcare world.

Managed care is the most important cost-management tool available to employers. We implore you to resist spoiling it in the good name of patient protection. Let's not try to turn back the clock to a time when health care was cheap enough to dish out without thought of cost. That time is past.

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry



835 SW Topeka Blvd. Topeka, Kansas 66612-1671 (913) 357-6321 FAX (913) 357-4732

SB 331 February 24, 1997

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

Senate Committee on Financial Institutions and Insurance

by

Terry Leatherman
Executive Director
Kansas Industrial Council

Mr. Chairman and members of the Committee:

My name is Terry Leatherman. I am the Executive Director of the Kansas Industrial Council, a division of the Kansas Chamber of Commerce and Industry. Thank you for this opportunity to comment on SB 331.

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.
KCCI is comprised of more than 3,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 47% of KCCI's members having less than 25 employees, and 77% having less than 100 employees. KCCI receives no government funding.
The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

As this Committee clearly understands, there are a couple of basic truths about health insurance in Kansas. Employers play a crucial role in the delivery of health insurance to Kansans, and economics is a major factor in an employer's decision on the level of participation in an employee health insurance plan. In recent years, some of the most successful approaches to

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c ɹining health insurance costs have involved negotiating cost containment with a network of health care providers.

KCCI's concern with SB 331 is how it might reverse these efforts to control health insurance costs. If negotiated fees are lost because exclusivity has been compromised, then the net effect of SB 331 might be higher insurance costs and more Kansans joining the roster of the state's uninsured population.

As a result, the Kansas Chamber would urge this Committee not to advance legislation which might adversely affect the cost of health insurance in our state. Thank you for this chance to comment on SB 331. I would be happy to attempt to answer any questions.

Kansas Senate Committee on Financial Institutions and Insurance
Testimony on SB 331
Cheryl Dillard; Vice President, Public Affairs; HealthNet
February 24, 1997

Mr. Chairman; Committee members. Thank you for the opportunity to appear before you today in opposition to SB 331. HealthNet is a large health plan in Kansas City. We are locally owned and operated by 8 community hospitals, including the St. Luke's-Shawnee Mission Health System and Bethany Medical Center. We offer PPO and HMO products to employers, public and private, in 85 counties in Missouri and Kansas.

I'd like to make three brief points in my testimony today to demonstrate that SB 331 is not needed in the current marketplace. The first is to clarify who is our customer. While pleasing our individual enrollees is uppermost in our operations, our primary customer is the entity that pays the bill and that is the employer. In HealthNet's case, that could be the state of Kansas, TWA, Sprint or 8,000 other employers throughout the two state region who have selected our products. We design products that, we believe, will fill a market need. We are fully prepared to make available any product that employers request. If employers want an HMO, we have that available. If they want to pay more money for the choice of additional providers, PPOs and POS plans are available in the market place now. A recent statistic from our national trade association, the American Association of Health Plans, states that about 80% of HMOs currently offer a POS plan, if employers would like to select it.

Secondly, I have provided you with the *Kansas City Business Journal*'s listing of top managed care plans in the Kansas City area. I wanted you to see how many HMOs, PPOs and POS plans are available to employers now. I would remind you that a PPO, Preferred Provider Plan, is what I call "managed care lite", with open access to all the providers in the network with no referral required. I'd call to your attention how many physicians and hospitals are available in the bi-state area. In HealthNet's own HMO product, we offer the choice of 322 pharmacies; 123 psychiatrists; 142 psychologists; 81 master's in social work; and 12 licensed professional counselors. Considerable choice of providers in all specialty areas are available now and will continue to be because our customers, the employers, want to offer their employees attractive health plans.

Finally, I would note that a mandatory POS law would work a considerable hardship on small health plans, like those that are being considered by rural hospitals. The Kansas Insurance Department prohibits HMOs from starting POS plans. Only by also becoming an insurance company or by affiliating with an insurance company can an HMO offer a POS plan. This would be extremely burdensome for smaller plans as well as for those plans where this open-ended care is inconsistent with their corporate mission.

In summary, if the goal of SB 331 is to provide enrollees in managed care plans with the choice of various providers and not merely to force on us those providers that have not currently been accepted into our networks, then we would maintain that there is already considerable choice in the marketplace.

Thank you for your time. I'd be happy to answer questions.

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2/24/97

Two Pershing Square, 2300 Main Street, Suite 700, Kansas City, Missouri 64108 (816) 221-8400; Fax (816) 221-7709

THE LIST

AREA MANAGED HEALTH CARE SYSTEMS

(HMOs ranked by current local enrollment)

1996 Rank	1995 Rank	Plan name Address Phone	Current local enrollment	Number of specialists	Number of physicians	Year licensed	Status	Number of hospitals contracted	Director Corporate affiliation
		Health Maintenance Organizations (HMOs)							
1.	2.	**CIGNA HealthCare of Kansas/Missouri Inc.** 7400 W. 110th St. Overland Park, Kan. 66210 339-4700 FAX 451-0974	69,000	784	1,188	1986	profit	18	Cynthia Finter CIGNA HealthCare
		Network Hospitals: Baptist Medical Center, Cass Medical Center, Children's Mercy Hospital, Independence Regional Medical Center, Lafayette Regional Health Center, Lawrence Memorial Hospital, Lee's Summit Hospital, Miami County Hospital, North Kansas City Hospital, Olathe Medical Center, Overland Park Regional Medical Center, Providence Medical Center, Ransom Memorial Hospital, Rehabilitation Institute, Research Belton Hospital, Research Medical Center, Saint John Hospital, University of Kansas Medical Center							
2.	3.	**Principal Health Care of Kansas City Inc.** 1001 E. 101st Terrace, Suite 300 Kansas City, Mo. 64131 941-3030 941-8516	59,464	1,795	2,304	1988	profit	37	Janet Stallmeyer Principal Financial Group
		Network Hospitals: Allen County Hospital, Baptist Medical Center, Bothwell Regional Health Center, Cass Medical Center, Children's Mercy Hospital, Cushing Memorial Hospital, Excelsior Springs Medical Center, Holton Community Hospital, Independence Regional Health Center, Lafayette Regional Medical Center, Lee's Summit Hospital, Liberty Hospital, Medical Center of Independence, Menorah Medical Center, Miami County Hospital, Mid-America Rehabilition Hospital, North Kansas City Hospital, Olathe Medical Center, Overland Park Regional Medical Center, Providence Medical Center, Ransom Memorial Hospital, Rehabilitation Institute, Research Belton Hospital, Research Medical Center, Saint John Hospital, Saint Joseph Health Center, Saint Luke's Hospital, Saint Luke's Northland-Barry Road, Saint Luke's Northland-Smithville, Shawnee Mission Medical Center, St. Francis Hospital and Medical Center, Stormont-Vail Regional Medical Center, Trinity Lutheran Hospital, Western Missouri Medical Center							
3.	5.	**Blue-Advantage** 2301 Main St. Kansas City, Mo. 64108 395-2222 FAX 395-2156	58,104	1,099	205	1992	profit	20	Larry Chastain TriSource Inc., a subsidary of Blue Cross and Blue Shield of Kansas City
		Network Hospitals: Baptist Medical Center, Children's Mercy Hospital, Lee's Summit Hospital, Medical Center of Independence, Menorah Medical Center, North Kansas City Hospital, Olathe Medical Center, Park Lane Medical Center, Providence Medical Center, Rehabilitation Institute, Research Medical Center, Trinity Lutheran Hospital, University of Kansas Medical Center, Atchison Hospital, Heartland Health System, Lawrence Memorial Hospital, Miami County Hospital, Ransom Memorial Hospital, Research Belton Hospital, Saint John Hospital							
4.	4.	**Kaiser Permanente** 10561 Barkley St., Suite 200 Overland Park, Kan. 66212 967-4733	51,058	380	414	1985	nonprofit	8	Kathryn Paul Kaiser Foundation Health Plan Inc.
		Network Hospitals: Baptist Medical Center, Children's Mercy Hospital, Medical Center of Independence, North Kansas City Hospital, Olathe Medical Center, Providence Medical Center, Research Medical Center, University of Kansas Medical Center							
5.	6.	**Blue-Care** 2301 Main St. Kansas City, Mo. 64108 395-2222 FAX 395-2156	41,936	1,099	512	1989	profit	27	Larry Chastain TriSource Inc.
		Network Hospitals: Baptist Medical Center, Children's Mercy Hospital, Excelsior Springs Medical Center, Lee's Summit Hospital, Liberty Hospital, Medical Center of Independence, Menorah Medical Center, North Kansas City Hospital, Olathe Medical Center, Overland Park Regional Medical Center, Park Lane Medical Center, Providence Medical Center, Rehabilitation Institute, Research Medical Center, Saint Luke's Hospital, Saint Luke's Northland-Barry Road, Saint Luke's Northland-Smithville, Shawnee Mission Medical Center, Trinity Lutheran Hospital, University of Kansas Medical Center, Atchison Hospital, Cass Medical Center, Heartland Health System, Lafayette Regional Health Center, Lawrence Memorial Hospital, Ransom Memorial Hospital, Research Belton Hospital, Saint John Hospital, Western Missouri Medical Center							
6.	nl.	**HealthNet Select** 2300 Main, Suite 700 Kansas City, Mo. 64108 221-8400 FAX 221-1870	38,686	1,246	426	N/A	profit	20	Andrew Dahl none
		Network Hospitals: Bethany Medical Center, Children's Mercy Hospital, Crittenton, Cushing Memorial Hospital, Excelsior Springs Medical Center, Independence Regional Health Center, Industrial Rehabilitation Center, Liberty Hospital, Mid-America Rehabilitation Hospital, Olathe Medical Center, Saint Joseph Health Center, Saint Luke's Hospital, Saint Luke's Northland-Barry Road, Saint Luke's Northland-Smithville, Saint Luke's Psychiatric Day Treatment, St. Mary's Hospital of Blue Springs, Shawnee Mission Medical Center, Valley Hope							
7.	7.	**Total Health Care** 2301 Main St. Kansas City, Mo. 64108 395-2222 FAX 395-2156	19,228	1,099	339	1981	nonprofit	27	Larry Chastain TriSource Inc.
		Network Hospitals: Baptist Medical Center, Bethany Medical Center, Children's Mercy Hospital, Excelsior Springs Medical Center, Lee's Summit Hospital, Liberty Hospital, Medical Center of Independence, Menorah Medical Center, North Kansas City Hospital, Olathe Medical Center, Overland Park Regional Medical Center, Park Lane Medical Center, Providence Medical Center, Rehabilitation Institute, Research Medical Center, Saint Luke's Hospital, Saint Luke's Northland-Barry Road, Saint Luke's Northland-Smithville, Shawnee Mission Medical Center, Trinity Lutheran Hospital, Truman Medical Center East, University of Kansas Medical Center, Atchison Hospital, Heartland Health System, Lawrence Memorial Hospital, Ransom Memorial Hospital, Research Belton Hospital, Saint John Hospital							
8.	8.	**Prudential HealthCare** 4600 Madison Ave., Suite 300 Kansas City, Mo. 64112 756-5588 FAX 756-5667	17,027	814	243	1986	profit	19	David Dingley Prudential Insurance Co.
		Network Hospitals: Baptist Medical Center, Bethany Medical Center, Cass Medical Center, Children's Mercy Hospital, Lafayette Regional Health Center, Lawrence Memorial Hospital, Lee's Summit Hospital, Liberty Hospital, Medical Center of Independence, Menorah Medical Center, Olathe Medical Center, Overland Park Regional Medical Center, Research Belton Hospital, Research Medical Center, Saint John Hospital, Saint Joseph Health Center, Saint Luke's Northlandl-Barry Road, Saint Luke's Northland-Smithville, Shawnee Mission Medical Center, Trinity Lutheran Hospital							
9.	10.	**HealthNet Excel** 2300 Main St., Suite 700 Kansas City, Mo. 64108 221-8400 FAX 221-1870	12,245	1,213	421	1992	profit	19	Andrew Dahl none
		Network Hospitals: See HealthNet Select.							
10.	11.	**The MetraHealth Cos.** 9300 W. 110th St., Suite 350A Overland Park, Kan. 66210 451-5656 FAX 451-0492	8,910	2,039	2,630	1987	profit	17	Rebecca Trankle United Healthcare
		Network Hospitals: Bethany Medical Center, Children's Mercy Hospital, Cushing Memorial Hospital, Excelsior Springs Hospital, Independence Regional Health Center, Liberty Hospital, Menorah Medical Center, North Kansas City Hospital, Olathe Medical Center, Park Lane Medical Center, Saint Joseph Health Center, Saint Luke's Hospital, Saint Luke's Northland-Barry Road, Saint Luke's Northland-Smithville, St. Mary's Hospital of Blue Springs, Shawnee Mission Medical Center, University of Kansas Medical Center							
11.	9.	**ExclusiCare** 7300 College Blvd. Overland Park, Kan. 66210 451-1777 FAX 451-7742	7,200	800	1,200	1990	profit	14	Kim Daniels Mutual of Omaha
		Network Hospitals: A listing was not available.							

A Health Maintenance Organization is a prepaid health plan that provides complete care for a set fee.

Information was compiled from questionnaires and telephone interviews with company representatives.

The following company did not respond to requests for information: Humana Health Care Plans

By Greg Stacey

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THE LIST

AREA MANAGED HEALTH CARE SYSTEMS

(PPOs and POS plans ranked by current local enrollment)

1996 Rank	1995 Rank	Plan name / Address / Phone	Current local enrollment	Number of specialists	Number of physicians	Year licensed	Status	Number of hospitals contracted	Director / Corporate affiliation
Preferred Provider Organizations (PPOs)									
1.	1.	**HealthNet** 2300 Main St., Suite 700 Kansas City, Mo. 64108 221-8400 FAX 221-1870	441,530	2,445	3,552	1984	profit	53	Andrew Dahl none
2.	2.	**Preferred-Care** 2301 Main St. Kansas City, Mo. 64108 395-2222 FAX 395-2156	273,798	N/A	3,473	1983	nonprofit	56	Richard Krecker Blue Cross and Blue Shield of Kansas City
3.	3.	**Preferred-Care Blue** 2301 Main St. Kansas City, Mo. 64108 395-2222 FAX 395-2156	205,947	N/A	2,938	1989	nonprofit	45	Richard Krecker Blue Cross and Blue Shield of Kansas City
4.	4.	**Preferred Health Professionals** 10955 Lowell Ave., Suite 300 Overland Park, Kan. 66210 339-4400 FAX 339-9804	95,000	2,499	3,733	1983	nonprofit	71	Sylvia Dochterman none
5.	6.	**Private Healthcare Systems Inc.** 2405 Grand Ave., Suite 1240 Kansas City, Mo. 64108 221-4455 FAX 221-4466	55,945	1,570	2,343	1985	profit	N/A	Shirley Cady Private Healthcare Systems Inc.
6.	5.	**Med Network** 1551 N. Tustin Ave., Suite 300 Santa Ana, Calif. 92705 (714) 953-9600 FAX (714) 953-6309	51,000	463	778	1978	profit	19	Wellington Stretton The ADMAR Corp.
7.	8.	**Principal Health Care of Kansas City Inc.** 1001 E. 101st Terrace, Suite 300 Kansas City, Mo. 64131 941-3030 FAX 941-8516	49,727	1,695	533	N/A	profit	57	Janet Stallmeyer Principal Financial Group
8.	10.	**The MetraHealth Cos.** 9300 W. 110th St., Suite 350A Overland Park, Kan. 66210 451-5656 FAX 451-0492	37,582	2,039	2,630	1987	profit	17	Rebecca Trankle United Healthcare
9.	7.	**Aetna Health Plans** 8700 State Line Road, Suite 110 Leawood, Kan. 66206 967-0462 FAX 967-0476	35,000	1,476	2,237	1986	profit	25	Mark Wilkman N/A
10.	9.	**CIGNA HealthCare of Kansas/Missouri Inc.** 7400 W. 110th St. Overland Park, Kan. 66210 339-4700 FAX 451-0974	25,000	1,450	2,099	1986	profit	33	Cynthia Finter CIGNA HealthCare
11.	12.	**Comprehensive Healthcare Ancillary Providers Inc.** 11503 W. 75th St., Suite 201 Shawnee, Kan. 66214 268-3322 FAX 268-6504	18,000	N/A	N/A	1991	profit	5	Larry Wells none
12.	nl.	**Occupational Health Management Inc.** 3101 Broadway, Suite 1000 Kansas City, Mo. 64111 931-7924 561-3819	15,000	585	450	1993	profit	16	Karen Goldsmith Independent Managed Care Organization
13.	13.	**Prudential HealthCare** 4600 Madison Ave., Suite 300 Kansas City, Mo. 64112 756-5588 FAX 756-5667	8,860	1,328	621	1991	profit	32	David Dingley Prudential Insurance Co.
Point-of-Service Plans (POS)									
1.	1.	**Prudential HealthCare** 4600 Madison Ave., Suite 300 Kansas City, Mo. 64112 756-5588 FAX 756-5667	52,253	847	300	1986	profit	19	David Dingley Prudential Insurance Co.
2.	2.	**CIGNA HealthCare of Kansas/Missouri Inc.** 7400 W. 110th St. Overland Park, Kan. 66210 339-4700 FAX 451-0974	41,000	784	1,188	1986	profit	18	Cynthia Finter CIGNA HealthCare
3.	3.	**The MetraHealth Cos.** 9300 W. 110th St., Suite 350A Overland Park, Kan. 66210 451-5656 FAX 451-0492	35,043	2,039	2,630	1987	profit	17	Rebecca Trankle United Healthcare
4.	4.	**Aetna Health Plans Managed Choice** 8700 State Line Road, Suite 110 Leawood, Kan. 66206 967-0462 FAX 967-0476	18,145	1,074	1,507	N/A	profit	15	Mark Wilkman N/A
5.	5.	**Private Healthcare Systems Inc.** 2405 Grand Ave., Suite 1240 Kansas City, Mo. 64108 221-4455 FAX 221-4466	4,214	680	984	N/A	profit	N/A	Shirley Cady Private Healthcare Systems Inc.
6.	nl.	**Preferred Health Professionals** 10955 Lowell, Suite 300 Overland Park, Kan. 66210 339-4400 FAX 339-9804	800	1,079	1,494	1983	non-profit	25	Sylvia Dochterman none

A Preferred Provider Organization negotiates discounted fees with physicians and hospitals for patient referrals.

A Point-of-Service Plan allows patients to seek treatment from providers in the plan or outside the plan for a higher co-payment. Many POS plans are being absorbed into HMOs & PPOs and do not have separate numbers.

The following company did not respond to requests for information: Humana Health Care Plans

By Greg Stacey

14-3

BRAD SMOOT
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Statement of Brad Smoot, Legislative Counsel
Blue Cross Blue Shield of Kansas
Senate Financial Institutions & Insurance Committee
1997 Senate Bill 331
February 24, 1997

Blue Cross and Blue Shield of Kansas is a nonprofit domestic mutual insurance company providing a variety of health insurance coverages to 720,000 Kansans in 103 counties. One of our products is a health maintenance organization (HMO) known as Premier Blue. This product was created to meet employer demand for a comprehensive benefit package at reasonable cost and is now serving hundreds of employer groups (464) and thousands of employees and their dependents (44,312). Thank you for this opportunity to express our concerns about mandating "point of service" reimbursements for out-of-network providers.

Mandated point of service legislation is not new. Proponents advanced a similar bill (HB 2985) last session which failed to leave the House FI&I Committee. Many of the same provider groups appeared as proponents while many of the opponents are the same. The issues are the same as well. And like so many debates legislators must endure, this one revolves around fundamentals. Allow me to discuss a few such fundamentals.

The market place. For decades Americans relied on a fee-for-service health care system. Between the unlimited supply of services and the seemingly unlimited demand for care, the cost of health care and corresponding cost of health insurance drove many out of the market place. Americans even considered, but rejected, a federal takeover of the health care delivery and financing system; choosing instead to rely on the marketplace for solutions. Managed care is that market place solution. It gives employers, employees and individual purchasers a variety of options in providing care and payment for that care. Through the use of primary care physicians who control utilization and price negotiations between third party payers and providers, the spiraling health care costs of a decade ago have been moderated. Unfortunately, the clear purpose and effect of SB 331 is to avoid these utilization controls, alleviate a provider's

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need to participate in networks and eliminate any provider incentive to negotiate favorable rates with health plans and their insureds.

Choices. Today employers and consumers have choices. They can buy a wide range of indemnity plans, preferred provider programs or HMOs. They can buy high deductibles and low deductibles. They can buy comprehensive or minimal coverage. An employer or individual can join an HMO and purchase the luxury of access to non network providers with a "self referral option" (SRO) available from most health care plans. Please remember that the point of this legislation is not to expand these choices but rather to limit them.

Cost. Employers who provide coverage for their employees want and need affordable coverage. While some employers can afford "Cadillac" plans, other cannot. As the payers of health care insurance, employers rightfully believe they ought to have some say in the scope and cost of the benefits they provide. For this reason, most health plans, including BCBS, offer a basic HMO and an HMO with a self referral option. See attached. But under SB 331, employers could no longer purchase just an HMO product. Instead, they must pay for all employee self referrals.

Employees are also losers under a mandated point of service law. Under SB 331 providers get reimbursed 90% of network rates. Nothing in the bill, however, limits the provider's ability to bill the patient for the balance of charges. The employee will be obliged to pay the 10% difference plus the difference between the network rate the providers' actual charges. Blue Cross Blue Shield contracts, on the other hand, restrict contracting providers to the agreed rate and forbid "balance billing."

The point of all this is that employers and employees have available to them a lot of choices in the marketplace, including traditional insurance, HMOs, and point-of-service programs such as an HMO with a self-referral benefit. To force all insurance to pay for services from out-of-network providers robs employers of choices and increases costs to employers and employees alike. SB 331 eliminates managed care and managed cost as options for Kansas health insurance consumers. For these reasons, we are opposed to SB 331.

Premier Blue (1996)
Comparison of Plan 1 and Plan 51

		Plan 1 (HMO)	Plan 51 (HMO & SRO)
Benefits			
Primary	Inpatient	$50 Copay (max 3/8 days)	$50 Copay (max 3/8 days)
	Professional	$10 Office Visit Copay	$10 Office Visit Copay
	Emergency Room	$50 Copay	$50 Copay
SRO		None	$200 Deductible 50/50 Coinsurance ($1000 max)
Rate			
Four Tier	Employee	$149.38	$161.25
	Employee/Child(ren)	$285.28	$308.00
	Employee/Spouse	$321.12	$346.71
	Employee/Dependents	$450.60	$493.42

Statement by: Bruce Witt
Preferred Health Systems, Inc.
Wichita, Kansas

To the Senate Financial Institutions and Insurance Committee regarding Senate Bill No. 331.

I want to thank you for allowing Preferred Health Systems the opportunity to provide testimony regarding Senate Bill No. 331.

Preferred Health Systems is the parent corporation of Preferred Plus of Kansas, a health maintenance organization, which has been authorized to transact HMO business in Kansas since November 22, 1991, and Preferred Health Systems Insurance Company, a life and health insurance company which has been authorized to transact life and health insurance business in Kansas since May 1, 1996. Our companies provide group life and health insurance coverage to employer groups in Kansas. Since becoming authorized in late 1991, Preferred Plus of Kansas has experienced significant growth in its HMO business which now totals approximately 55,000 members. Preferred Health Systems Insurance Company was only recently licensed in Kansas, but we anticipate similar growth now that we have the ability to offer employer groups a wider range of life and health insurance products including PPO and Point-of-Services plans.

As you are all aware, more money is spent on health care per person in the United States that anywhere else in the world, and each year it costs even more. High rates of inflation in medical costs and continued high utilization rates, as well as a large uninsured population, continue to drive up health care costs. At the same time, the number of people without health insurance keeps rising. In today's health insurance marketplace, it is more and more evident that managed care, which integrates the financing and delivery of appropriate health care services to covered individuals, is the most promising strategy for reforming the health care system. Managed care organizations strive to deliver the most appropriate level of care, in the most appropriate setting, at the appropriate time to produce the desired clinical outcome. simply stated, Preferred Health Systems believes that this approach provides the greatest value to consumers by delivering high quality care in a cost effective manner.

We are extremely concerned that if passed, Senate Bill No. 331 would severely limit, if not eliminate our ability to continue offering high quality, competitively priced health insurance products to employer groups in Kansas. In order to achieve their full potential, HMOs and Point-of-Service plans must have the ability to provide incentives to their members to utilize the network of health care providers designated to deliver high quality, yet cost effective health care. The requirement under Section 7(b) of Senate Bill No. 331 that health care services rendered by a non-network provider be covered in an amount not less than 90% of the amount which would be paid if the such services were rendered by a network provider would virtually eliminate any incentive for a member to seek services from their primary care physician, or any contracting provider participating in an HMO or Point-of-Service plan. By eliminating the incentive for a member to seek health care services within the network and structure of a managed care plan, the impact of this type of legislation would be a substantial rise in health care costs, since managed care plans will not have the ability to effectively control such medical costs by directing their members to the most appropriate and cost effective health care services. We would most likely experience the levels of inflation in medical costs in the 1970s and 1980s, which resulted in premium increases at annual rates of up to 50%. During that time period employers found that

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traditional arrangements for financing their employee's health care were compromising the profitability, even the viability, of their businesses.

Between 1994 and 1997, Preferred Health Systems affiliates have frequently been able to limit premium increase percentages to single digits and have at times been able to reduce premiums. We feel Senate Bill No. 331 would halt the progress that has been made in holding medical costs down to single digit inflation levels in recent years, and, because many small employers would not be able to afford group health insurance, would only add to the already growing problem of the uninsured in this state.

We urge the Chairman and Committee to oppose this bill as it will have detrimental effects to the managed care industry which now provides health insurance coverage to more than 50% of the employer-sponsored health plans in Kansas.

M E M O R A N D U M

TO: The Honorable Don Steffes, Chairman
Senate Financial Institutions and Insurance Committee

FROM: William W. Sneed
Health Insurance Association of America

DATE: February 21, 1997

RE: SB 331

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I appear before you today on behalf of the Health Insurance Association of America (HIAA). We appreciate this opportunity to testify in opposition to SB 331.

SB 331 would require health insurers who utilize a system of network providers to pay for health care services rendered by a non-network provider at a rate of not less than 90% of the rate the insurer would have paid for services rendered by a network provider. This legislation restricts consumers' rights to contract with a health insurance company, restricts consumers' rights to choose between plans offering different types and levels of benefits, and has the effect of driving up the cost of health insurance.

The network provider system was developed in response to rising health insurance costs. Contracting with certain providers and building a network allows an insurer to contain costs and provide a less expensive product to the consumer. A vast majority of these network provider systems include payment of benefits for service rendered outside the network; however, the level of payment is somewhat less. This feature, while controlling costs, does not unduly limit the consumer's choice of health care providers or services. The consumer remains free to choose a

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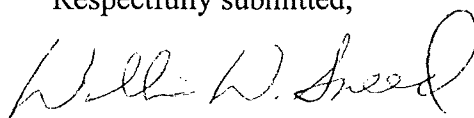
non-network provider, but is simply expected to bear a bit more of the cost.

Further, under current law, the consumer is free to choose a plan which does not utilize the network system and does not feature a payment differential between network and non-network providers. Many such products exist in the market today, and are available for purchase. However, the network provider system is another choice which has proven popular in the market because of its lower cost.

SB 331 would completely eliminate consumer choice in this area. Consumers would be forced to purchase a product with little differential between level of benefits paid to network and non-network providers--a product which is likely to be much more expensive than current products which do not labor under this legislation's restrictions. We ask that you not force the consumer to give up the choice and pay more for the resulting product.

We appreciate this opportunity to testify in opposition to SB 331. Please do not hesitate to contact me if you have questions or need further information.

Respectfully submitted,



William W. Sneed

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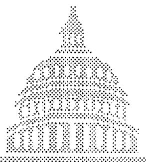
PETE McGILL & ASSOCIATES INC.

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Testimony In Opposition To SB 331

Offered By

John J. Federico - Pete McGill & Associates

On Behalf of

Humana Health Care Plans

Senate FI&I Committee

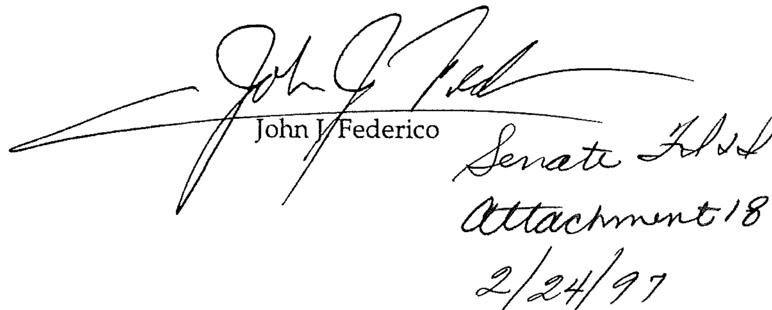
February 24, 1997

My name is John Federico of Pete McGill & Associates, and on behalf of Humana Health Care Plans, stand before you today in **strong opposition** to SB 331.

In 1996 Humana acquired the Employers Health Insurance Company and today maintains one of the largest HMO networks in the country. Like many other managed health care plans, Humana has benefited from the shift away from traditional fee-for-service health delivery services to a managed care/gatekeeper approach. This shift was not accidental, rather, it spawned from the growing intolerance for rising health care and, insurance premium costs!

The shift to managed care has not entirely stripped the health care consumer of "choice." The introduction of POS products is already occurring in the marketplace in response to employee and employer concerns and preferences. Humana supports the ability of consumers to select the health plan and health care provider of their choice, and offers numerous PPO products that are available in addition to their HMO products. (In fact, the majority of individuals we cover have benefit plans which allow for out-of-network provider access.)

However, we believe that health plans must also be free to respond to the pressure of rising health care and premium costs. For some consumers, their access to care is directly related to premium costs! In short, numerous health insurance products are currently available to the health care consumer and market forces should drive these decisions not legislative mandates as spelled out in SB 331! Thank you.



Statement of Kaiser Permanente re: SB 331

Thank you for the opportunity to express the concerns of Kaiser Permanente with Senate Bill 331.

Kaiser Permanente is a not-for-profit HMO which provides prepaid health care to nearly 60,000 members in the Kansas City area. Kaiser Permanente is a group practice HMO. As such, the physicians of Kaiser Permanente provide health care exclusively and directly to our members in Kaiser Permanente medical offices, and our members choose a Kaiser Permanente physician as a primary care physician. Kaiser Permanente is a direct provider of health care, not an insurer which pays claims or contracts with a widely scattered network of providers.

Kaiser Permanente was the first HMO in the state of Kansas to receive full accreditation status from the National Committee for Quality Assurance, the nation's premier quality monitoring organization for HMOs.

SB 331 would force Kaiser Permanente to assume the role of an indemnity insurance company that pays claims on a fee-for-service basis. It also would diminish the role of the Kaiser Permanente physician in coordinating care for our members.

This proposal would compromise Kaiser Permanente's ability to provide quality care, control costs, and to price health care at a level affordable to consumers. In addition, SB 331 would make HMOs, including Kaiser Permanente, less able to fulfill their preventive care obligations.

And lastly, SB 331 would have a significant effect on health care costs to Kansas consumers. As you may recall, similar point of service proposals were offered during the 1994 national health care reform discussions. As the attached KPMG Peat Marwick study illustrates, it was estimated that a national point of service mandate would have added $350 to $540 to an average family's annual premium, in 1994 dollars.

Kaiser Permanente has been a leader in providing affordable, quality health care to Kansas consumers. Passage of SB 331 would significantly affect our ability to continue doing so, and that is why we oppose it. Thank you.

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Kaiser Foundation Health Plan of Kansas City, Inc.
10561 Barkley, Suite 200 Overland Park, Kansas 66212 (913) 967-4600

CIGNA

Carole Olson Gates
Counsel
Regional Vice President
Government Affairs

120 W. 12th Street
Suite 1440
Kansas City, MO 64105
Telephone 816.374.7326
Facsimile 816.374.7190

Senate Bill 331
Senate Financial Institutions and Insurance

Chairman Steffes and members of the Financial Institutions and Insurance Committee:

I am Steve Kearney, appearing on behalf of CIGNA Corporation which includes CIGNA HealthCare of Kansas City. We appreciate you willingness to work with managed care in addressing many of the concerns that have been raised by this measure. We appear here today in opposition to SB 331.

This measure is so broad that it will force a major revamping of our current system of managed care in Kansas. SB 331 appears not only to create a point of service mechanism, but a fee for service framework. The few indemnity plans that are currently offered would embrace just such a system. However, the cost of such a plan is not usually the choice of employers.

Enactment of SB 331 will create an environment where the managed care plans will be less able to manage costs and as a result all managed care products will be priced higher. For example, just on the pharmacy side of this measure, the ability to go out of network will make it impossible for insurers to predict volume, which is the basis for the discounted prices that the insurers negotiate with in-network providers. It also significantly alters HMOs' ability and the treating physicians' ability to monitor the patients' use of out-of-network prescriptions.

Our actuaries quick review of this measure indicate as follows:

1. Medical costs will increase approximately 40%
    a. 25% would be a result of losing the ability to negotiate discounts.
    b. 15% would relate to the inability to perform any sort of medical management or utilization management.
2. Pharmacy costs would increase approximately 25-30% on top of the medical cost increase.

Total: 65-70% estimated increase.

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Statement in Support of S.B. 331
Carl C. Schmitthenner, Jr.
Executive Director
February 24, 1997

Mr. Chairman and members of the Committee, on behalf of the Kansas Dental Association, I am pleased to support S.B. 331. The Kansas Dental Association strongly supports this bill, because it will ensure patient freedom of choice of provider for patients. Patients in managed care plans will have the opportunity to seek care from a non-network provider and receive a somewhat lower level of reimbursement than would be the case if the patient sought care from a network provider.

S.B. 331 provides a fundamental level of fairness for patients and allows them to make informed choices about their health care.

I appreciate your consideration of these comments and respectfully request your support of this important legislation.

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Topeka, Kansas 66604-2398
913-272-7360

Senate F I & I
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